Customer Report of Dissatisfaction
Short-Term Disability

This form is to be used to provide information to the Employee Health Initiatives Division, Disability Management Unit regarding an adverse customer service experience with the short-term disability vendor. Either the employee or the employer on behalf of the employee may complete this form.

Employee Information

Last Name _____ First Name _____

Department Name _____ Daytime Telephone Number _____

Email Address _____

Vendor Information

Identify the vendor, the person(s) with whom you had contact with at the vendor, the phone number(s) you called to speak to the vendor contact, and the date of contact. If multiple contacts were made, please include this information in the description of events section.

Vendor Name _____ Name of Person Contacted at Vendor _____

Phone Number of Contact Person _____ Date of Contact _____

Description of Events

Fully describe your customer service experience including what you requested, what service did not meet your expectation, and what action you are requesting from the vendor. If additional space is required, please attach an additional sheet of paper.

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Signature of person filing the report _____ **Date** _____ **Daytime Telephone Number** _____

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Process

1. Employee Health Initiatives Disability Management representative/department contact (i.e., MIHS, Sheriff's Office & Human Services) completes Section below, sends form to the vendor, enters data into tracking log and pends for response. A copy of the form will also be sent to Karen Bejarano, Employee Benefits.
2. Vendor investigates the complaint by contacting the person filing complaint (employee or employer-department contact) to discuss the complaint & resolve issue.
3. Vendor completes response section below and faxes to Disability Management representative or department contact with response/resolution within 14 calendar days. If issue remains unresolved as of the 14th day, vendor will provide a status report on steps taken to resolve the issue. Vendor will continue to provide status reports at 14-day intervals until the issue is completely resolved.
4. Disability Manager or department contact follows up with the employee or employer-department contact to ensure issue has been addressed/resolved.
5. Disability Manager codes form with Problem Type and enters data into tracking log.

Employee Health Initiatives Disability Manager or Department Contact Information

Last Name _____ First Name _____

Telephone Number _____ Email Address _____

Fax Number _____ Date form forwarded to vendor _____

Vendor Response

Describe your findings regarding the complaint including who was contacted and what action(s) was taken to resolve the issue. If additional space is needed, please attach a separate sheet.

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Last Name, First Name _____ Title _____

Telephone Number _____ Email Address _____

Disability Management Office Use Only:

Type of Problem

☐ Disrespectful treatment by vendor ☐ Phone call not returned by vendor ☐ Delay in processing claim
☐ Non-receipt of check ☐ Failure to communicate
☐ Other Unresolved issue:_____